REQUEST FOR MEDICARE PART D DRUG PLAN COMPARISON

By completing this form, the requester will receive by mail, fax, or email, a Part D general comparison listing the three lowest annual cost plans as published on www.medicare.gov. The State Health Insurance Assistance Program (SHIP) is a program of the State's Department of Insurance and will provide this information at no cost and does not endorse any of the plans. This form should be mailed to the Indiana Department of Insurance, State Health Insurance Assistance Program (SHIP) ATTN: Kelli Lacy, 714 W. 53rd St., Anderson, IN, 46013, or faxed to 765-608-2322. Please provide the following information:

Zip Code: _____ County: _____

Do you get Extra Help Paying for Your Drug Costs? Not sure – see the bottom of the back page. No ☐ Yes (Full ☐ Partial ☐) If Partial, what is the %_____

What type of Medicare do you receive now? Original Medicare ☐ Medicare Health Plan (PPO, HMO, etc.) ☐ No Medicare coverage yet ☐

Do you want your health and drug coverage together in one plan? (Medicare Health Plan PPO, HMO, etc) Yes ☐ No ☐

Do you want Prescription Drug coverage only? (Medicare Prescription Drug Plan) Yes ☐ No ☐

Will you use generic medications? Yes ☐ No ☐

Phone Number: _____

Name: _____

Address: _____

City, State, and Zip Code _____

PLEASE COMPLETE DRUG INFORMATION ON BACK OF THIS PAGE

OFFICE USE ONLY

Date Paperwork Sent: Date Received: Date Processed .

Drug List ID Password: .

Date Mailed: Emailed: Faxed: .

Phone Contact: Completed By: .

Please list your drugs and dosages as they appear on your prescription bottle or package on the chart on back of this form. Make sure that you spell the name of the drug correctly. **Do not include over-the-counter medications such as pain relievers and vitamins.**

Which Pharmacy do you use?_____

DRUG NAME – this must be spelled correctly	**DOSAGE**	**QUANTITY PER DAY**	**REFILL FREQUENCY (1 month)**

You may qualify for extra help paying for your Part D prescription costs if your resources are limited to $13,440 for an individual or $26,860 for a married couple living together. Your monthly income must also be limited to $1,478 for an individual or $1,986 for a married couple living together. Even if your monthly income is higher, you still may be able to get some help. For more information, contact your local Area Agency on Aging at 1-800-986-3505 or call SHIP at 1-800-452-4800.

ship NATIONAL NETWORK state health insurance assistance programs

LOCAL HELP FOR PEOPLE WITH MEDICARE